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CONNECTICUT ONCOLOGY ASSOCIATION

STEPHEN GRUND

February 18, 2010

State of Connecticut
Insurance and Real Estate Committee
Room 2800, Legislative Office Building
Hartford, CT 06106

Re: Testimony in support of Raised Senate Bill 50 An Act Concerning Oral Chemotherapy Treatments

ATTENTION: Senator Crisco, Representative Fontana and members of the Committee

Greetings:

The Connecticut Oncology Association (CtOA) is a non-profit organization dedicated solely to oncology care in the state of Connecticut. The Connecticut Oncology Association is the sole professional organization for Connecticut practicing oncologists and their practices. Its mission is to provide education and facilitate communication on issues affecting oncology and the access to quality cancer care for patients in the state.

CtOA is here today to address Raised Senate Bill No. 50, which is now under consideration by the Insurance and Real Estate Committee. On behalf of our patients and our own dedication to the continued access to quality cancer care in Connecticut, we appreciate your vision in considering this raised bill, and would like to lend our support to your efforts.

During the battle of the last four decades on cancer, we have successfully moved the majority of cancer treatments from the more costly inpatient setting into the outpatient and private community oncology practice office. That success is due in large part to the advances in technology and the emergence of new, innovative agents for treating cancer.

The evolution of oncology treatment has outpaced payer and employer management of healthcare benefits. Historically, intravenous/injected chemotherapy agents are typically covered under medical benefit plans, since due to the complexity of cancer care and the toxicity of the drugs, they are delivered under the care of a physician in the office setting. The medical benefit coverage provides patient responsibility for office visit copayments and may include a cap on out-of-pocket expenditures, making necessary treatment for cancer care affordable and accessible for patients.

However, with the recent emergence of orally-administered anticancer agents, payers have moved insurance of many of these agents to the pharmaceutical benefit, which allows the creation of benefit structures that vary significantly and can create a significant financial burden to the cancer patient. It is important to note that evidence-based treatment guidelines, including those issued by the National Comprehensive Cancer Network (NCCN) recommend a variety of combinations of cancer treatments depending upon the individual cancer and stage, and the ability of the patient to tolerate the treatment. These recommendations are made without regard to the route of administration, expecting the physician to determine the most appropriate option for each patient. Restrictive benefit structures that differ between the medical and pharmaceutical benefit are interfering with the medical decision-making and preferred course of treatment for both physicians and patients.

Raised Senate Bill No. 50 proposes to level those differences in benefit structures, so that cancer patients will not be faced with the choice of no treatment, choice of the least costly alternative, or the preferred treatment for their individual cancer. This raised bill will define coverage expectations so that cancer patients may have access to the most appropriate agent for cancer treatment, and not worry that the treatment they need will not be covered under their insurance's medical benefit, or that the costs of co-payments if the drug is only available in the pharmacy benefit will make that same medication completely out of their reach financially.

This is not a cost of drug issue, it is a coverage issue. The difference in cost between the oral and IV versions of drugs is not significant. However, the patient may be forced to pay thousands of dollars more out of pocket for the same medication, depending upon whether the payer covers it under the medical benefit or the pharmaceutical benefit. In another worst case scenario, the patient may not have access at all to a drug they could have received in the office, because their pharmaceutical benefit does not cover that drug in oral form.

Due to complex state pharmacy regulations, many oncologists do not dispense oral medications in their offices, but they do see patients every day, who are prescribed needed anti-cancer agents, only to find that the patient has to decline the drug because their insurance may not have a pharmaceutical benefit, or their pharmaceutical insurance package places anti-cancer drugs in the highest tiers for co-payments and co-insurance, rendering them unaffordable. Some anti-cancer agents are only available in oral form and thus not accessible under the medical benefit, others are available in both oral and IV form but are only accessible to patients under the medical benefit due to differences in financial burden to those patients for the same drug under a pharmaceutical benefit.

This access problem for our patients will continue to exacerbate, with more than 25% of the drugs in the cancer pipeline being developed in an oral formulation. We must move now to ensure parity between patient access to both IV and oral cancer treatments, regardless of which insurance benefit they hold. To allow payers to create different reimbursement structures that become barriers to care is a gross injustice to the people of Connecticut who are already battling the fight of their lives against cancer.

The CtOA urges the Connecticut legislature to quickly pass Raised Senate Bill No. 50, and stop the barriers to care that are restricting needed access to treatment for cancer patients. No matter what the route of administration is (oral, intravenous or injectable) for the preferred treatment for patients, the out-of-pocket cost to that patient should be equivalent and affordable. We therefore recommend, additionally, that verbiage be added to Raised Senate Bill No. 50 assuring that cancer patients not only receive the prescribed therapies based upon their potential efficacy by the prescribing oncologist, whatever the formulation, but also that they are not unjustly assessed unachievable co-pays and co-insurances as seen by recent revised legislation in the state of Oregon and others, as well as private insurance company trends of drug formulary tier placement resulting in a higher patient cost share than other formulations, even for the same medication.

Sincerely,

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